

00755

CERTIFICATE OF DEATH

00755

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ABERDEEN</u>		c. LENGTH OF STAY in 1b <u>30 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ABERDEEN</u> <u>12-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RE. O. #2 Bldg 174</u>				d. STREET ADDRESS <u>RED #2 Bldg 174</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MAUD</u> Last <u>BALL</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>23</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 20, 1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN R. SMITH</u>				14. MOTHER'S MAIDEN NAME <u>BLANCHE B. GORRELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>213-35-5452</u>		17. INFORMANT <u>JOHN S. BALL, ABERDEEN R.L. 2 Bldg 174, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>1221</u> DUE TO (b) <u>Arteriosclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>C.H.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced Hypertrophic Cardiomyopathy</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1963</u> to <u>Jan 23, 1967</u> , that (I) (we) last saw the deceased alive <u>Jan 23, 1967</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Ralph Horky</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. RALPH HORKY</u>				22d. ADDRESS <u>ABERDEEN, MD R.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN. 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHURCHVILLE RESBY TERN</u>		23d. LOCATION (City, town or county) (State) <u>HARFORD, Co. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell, Harrod, Grace, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1 (M)</p> <p>00756</p> </div> <div> <p>STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>00756</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Hartford</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u></p> <p>c. LENGTH OF STAY IN 1b <u>11 days</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Md</u> b. COUNTY <u>Hartford</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u></p> <p>d. STREET ADDRESS <u>815 Erie Street</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Rachael</u> Middle <u>Bernardi</u> Last <u>Bernardi</u></p>						<p>4. DATE OF DEATH</p> <p>Month <u>JANUARY</u> Day <u>1</u> Year <u>1967</u></p>					
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>1898</u></p> <p><u>2/22/1898</u></p>		<p>9. AGE (In years last birthday) <u>68</u></p> <p>Months <u>6</u> Days <u>18</u> Hours <u>15</u> Min. <u>00</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u></u></p>				<p>11. BIRTH PLACE (County & State, or foreign country) <u>Italy</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Joseph Maullo</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>Catherine Costabile</u></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>						<p>16. SOCIAL SECURITY NO. <u>615-100-1000</u></p>		<p>17. INFORMANT <u>Nicholas Bernardi</u> Address <u>815 Erie St., Havre de Grace Md 21078</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Metastatic Ca. of the brain</u></p> <p>163X</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) <u>Adenocarcinoma, left lung</u></p> <p>(c) <u></u></p>										<p>INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u></p>											
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/></p>						<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u></p>					
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. <u>19</u> p.m. <u></u></p>				<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u></p>		<p>20f. (City or town) (County) (State) <u></u></p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 21, 1966</u> to <u>JAN 1, 1967</u>, that (I) (we) last saw the deceased alive on <u>JAN 1, 1967</u>, and that death occurred at <u>4:51 AM</u>, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE <u>Edmund C. Loo, M.D.</u></p>						<p>22b. DATE SIGNED <u>1/1/67</u></p>		<p>22c. PHYSICIAN'S NAME (Type) <u>Edmund C. Loo, M.D.</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/4/67</u></p>						<p>23b. DATE THEREOF <u>1/4/67</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Elm</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Havre de Grace, Md</u></p>	
<p>24. FUNERAL DIRECTOR <u>Funeraria of Havre de Grace Md.</u></p>						<p>25a. REC'D BY REGISTRAR <u>J. Charles Judge</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u></p>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00757

CERTIFICATE OF DEATH

00757

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode-Grace</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>118 E. Main St, Elkton</u>			
3. NAME OF DECEASED (Type or print) <u>Eleanor Mae Biles</u> First Middle Last				4. DATE OF DEATH <u>1</u> <u>11</u> <u>1967</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1894</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woolworth</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Lilley</u>				14. MOTHER'S MAIDEN NAME <u>Cramer</u> <u>Lilley, Sarah</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Gifford B. Biles, Elkton, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <u>CVA. Cerebral hemorrhage (massive)</u> DUE TO (c) <u>Hypertension H.C.V.D.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>2 hrs.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-15, 1960</u> , to <u>1-11, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-11-1967</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Luis M. Cuza</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LUIS M. CUZA M.D.</u>				22d. ADDRESS <u>322 E. Cecil Ave. North East, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary Anne's Cemetery, North East, Md.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Hicks Home for Funerals, Elkton, Md.				DATE <u>JAN 13 1967</u>			

MEDICAL CERTIFICATION

00124

00124

Bill 3 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>00758</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>00758</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford - Grace</u>			c. LENGTH OF STAY IN 1b <u>31 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DARLINGTON, MD</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>					d. STREET ADDRESS <u>Smith Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Bostic</u>					4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 13, 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH Bostic</u>					14. MOTHER'S MAIDEN NAME <u>HANNAH MAIN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WWI</u>					16. SOCIAL SECURITY NO. <u>162-09-3131A</u>				
					17. INFORMANT <u>Wm. F. Bostic, Harford Grace, MD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12-22</u> , 19 <u>66</u> , to <u>1-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/11</u> , 19 <u>67</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Dudley Phillips</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/12/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>					22d. ADDRESS <u>DARLINGTON, MD 21034</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>1-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>		23d. LOCATION (City, town or county) (State) <u>DARLINGTON, MD.</u>		
24. FUNERAL DIRECTOR <u>John H. Harkins, DELTA, PA.</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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00759

CERTIFICATE OF DEATH

00759

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		d. STREET ADDRESS Box 24-A Northeast Rd.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C. Last BRINEGAR		4. DATE OF DEATH Month January Day 23 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 July 1923
9. AGE (In years last birthday) yrs. 43		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Heavy Equip. Sect. U.S. Govt. Wilkes Co., N.C.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William K. Brinegar		14. MOTHER'S MAIDEN NAME Clyde Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. 238-22-7314	
17. INFORMANT Van Brinegar, Aberdeen, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-8-66 , 19 67 , to 1-23- , 19 67 that (I) (we) last saw the deceased alive on 1-20- , 19 67 , and that death occurred at 11:50 AM , and that death was caused by Adm. causes and on the date stated above.			
22a. SIGNATURE Peter P. Rodman		22b. DATE SIGNED 1-24-67	
22c. PHYSICIAN'S NAME (Type) Peter P. Rodman		22d. ADDRESS 8 Law Street, Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 25 Jan. 67	
23c. NAME OF CEMETERY OR CREMATORY Whitehead Cemetery		23d. LOCATION (City or Town) (County) (State) Whitehead, North Carolina	
24. FUNERAL DIRECTOR Welsh Macoruba Jr.		25a. REC'D BY REGISTRAR Tarring Funeral Home	
25b. REGISTRAR'S SIGNATURE Aberdeen, Md.		DATE JAN 26 1967 Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00760					00760				
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>			c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace, Md.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Citizens Nursing Home</u>					d. STREET ADDRESS <u>612 S. Union Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>E.</u> Last <u>Brown</u>					4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 23, 1903</u>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford County, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Barrett</u>					14. MOTHER'S MAIDEN NAME <u>Laura Hall</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>212-16-2749A</u>		17. INFORMANT <u>Mrs. Mabel E. Whit, Harve de Grace, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis with Cerebral Involvement</u> 15-01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) <u>Carcinoma of the Colon</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10/18</u> , 19 <u>66</u> , to <u>1/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>67</u> , and that death occurred at <u>2:20</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>George T. Stansbury,</u>					M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/19/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury,</u>					22d. ADDRESS <u>569 Revolution St. Harve de Grace, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Jan. 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Methodist Cm.</u>		23d. LOCATION (city, town or county) (State) <u>Churchville Harford Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Otha J. Bullock, Harve de Grace, Md.</u>					25a. REC'D BY REGISTRAR, 25b. REGISTRAR'S SIGNATURE DATE <u>JAN 23 1967</u> <u>Charles Judge</u>				

00761

CERTIFICATE OF DEATH

00761

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood			c. LENGTH OF STAY IN 1b 3 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2016 Armstrong Street				d. STREET ADDRESS 2016 Armstrong Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANTHONY Middle - Last BURBAR				4. DATE OF DEATH Month JANUARY Day 5 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1897		9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months 5 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sgt.		10b. KIND OF BUSINESS OR INDUSTRY USA - Retired		11. BIRTHPLACE (County & State, or foreign country) Sima, Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Burbar				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI and WWII		16. SOCIAL SECURITY NO 215-24-6948		17. INFORMANT Address Edgewood, Md. Mrs. A. Ellen Burbar, 2016 Armstrong St.,			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary heart disease DUE TO (c) Pulmonary emphysema							INTERVAL BETWEEN ONSET AND DEATH 5 years 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Kirk Army Hospital attended the deceased from April , 19 66 to January , 19 67 , that (I) (we) last saw the deceased alive on 16 December 1966 , and that death occurred at 4:00 A.M. from causes on and on the date stated above.							
22a. SIGNATURE Ronald M. Severino				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RONALD M. SEVERINO, CAPTAIN, MC				22d. ADDRESS Kirk Army Hospital, APG, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or town) (County) (State) Ft. Myer Va.	
24. FUNERAL DIRECTOR Stanley K. McComas & Son, Abingdon, Md.				25a. RECEIVED BY REGISTRAR DATE JAN 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00762

CERTIFICATE OF DEATH

00762

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 143 Thomas St.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital				e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Allen Last CHANDLER		4. DATE OF DEATH Month Jan Day 4 Year 1967		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 January 66		9. AGE (in years last birthday) yrs. 11 Months 11 Days 3		IF UNDER 1 YEAR Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Harford, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew L. Chandler				14. MOTHER'S MAIDEN NAME Bonnie C. Fuller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Father (Same as above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 4/15A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Vomitting DUE TO (c) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 Days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 4 Jan , 19 67 , to 4 Jan , 19 67 , that (I) (we) last saw the deceased alive on 4 Jan , 19 67 , and that death occurred at 9:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE <i>William J. Peter</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM J. PETER, CPT., MC				22d. ADDRESS Kirk Army Hospital, APG, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7 Jan. 67		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Maryland		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <i>John G. Tarring</i>				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
DATE JAN 6 1967							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00763

00763

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>3801 Old Phila. Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Emory Coe</u>				4. DATE OF DEATH Month Day Year <u>January 14 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. WIDOWED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 14, 1878</u>	9. AGE (in years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Moses P. Coe</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Butler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-38-4829</u>		17. INFORMANT Address <u>Abingdon, Md.</u> <u>Mrs. Walter R. Famous, 3108 Old Phila. Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial A.S.C.V.D.</u> <u>561.0</u> DUE TO <u>C.V.A.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration</u> (c) <u>Incarcerated for unpaid term</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 12, 1967</u> to <u>JAN 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN 14 1967</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Henry H. Kwak</u>				22b. DATE SIGNED <u>14 Jan. 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>HENRY H. KWAK</u>				22d. ADDRESS <u>608 S. Union Ave. Harford Co. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville Cemetery</u>		23d. LOCATION (city, town or county) (State) <u>Jarrettsville, Harford Co. Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>JAN 17 1967</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00764

CERTIFICATE OF DEATH

00764

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAYRE de GRACE				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air			
c. LENGTH OF STAY IN 1b 2 days				d. STREET ADDRESS 115 Woodland Dr.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle Bertha Last DAVIS		4. DATE OF DEATH Month JAN Day 16 Year 1967		5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 25, 1901		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Mareck				14. MOTHER'S MAIDEN NAME Bessie Estes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Address 115 Woodland Mrs Jean D. Hart (Drive Bel Air, Md.)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Over-dose of Coumadin (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) A.S. C.V.D. & Congestive Changes & pulmonary edema							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from Dec 14, 1966 to Jan 16, 1967 , that (I) (we) last saw the deceased alive on Jan 14, 1967 and that death occurred at 3:00 PM from the causes and on the date stated above.							
22a. SIGNATURE Edward C. Lee M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1/16/67			
22c. PHYSICIAN'S NAME (Type) Edward C. Lee, M.D.				22d. ADDRESS Hayre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/19/67		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR SPR 3901 N. Fairfax Dr. Arl., Va.				25a. REC'D BY REGISTRAR JAN 19 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00765

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harvre de Grace		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, rural	
3 NAME OF DECEASED (Type or print) Richard Wilson Dorsey, Jr.		4 DATE OF DEATH Month 1 Day 21 Year 67	
5 SEX male	6 COLOR OR RACE colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 30, 1927
9 AGE (In years birth day) yrs 39		10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b KIND OF BUSINESS OR INDUSTRY A.P.G.	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Richard W. Dorsey Sr.		14 MOTHER'S MAIDEN NAME Elsie P. Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1945-49		16. SOCIAL SECURITY NO. 217-20-2063	
17 INFORMANT Elsie P. Dorsey, Port Deposit, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive left hemothorax DUE TO (b) Stab wound of neck involving subclavian artery and lung. (c) and lung.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) stabbed during altercation			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) stabbed during altercation	
20c TIME OF INJURY Month, Day, Year 3:30 am 1 21 19 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc) home		20f (City or town) (County) (State) Port Deposit Cecil Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 1/21/67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 1-25-67	23c NAME OF CEMETERY OR CREMATORY Jones Memorial Cem	23d LOCATION (City or Town) (County) (State) Port Deposit Md.
24 FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		25a REC'D BY REGISTRAR FEB 1 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00766				CERTIFICATE OF DEATH				00766			
1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> c. LENGTH OF STAY IN 1b <u>27 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> d. STREET ADDRESS <u>353 Congress Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Beulah Gertrude Dragon</u>				4. DATE OF DEATH <u>JANUARY 15 1967</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/31/1902</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Store</u>		11. BIRTH PLACE (County & State, or foreign country) <u>Havre de Grace Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Broadwater</u>				14. MOTHER'S MAIDEN NAME <u>Grace Duffish</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Vincent Broadwater, Havre de Grace</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X cerebral-vascular hemorrhage</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 15, 1967</u> to <u>JAN 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN 16, 1967</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Ann H. Wadman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/17/67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS							
23a. (BURIAL) CREMATION, REBURYAL (Specify)				23b. DATE THEREOF <u>1/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City, town or county) (State) <u>Havre de Grace Md</u>			
24. FUNERAL DIRECTOR <u>Truman R. Pan</u>				ADDRESS <u>Havre de Grace Md</u>		25a. REC'D BY REGISTRAR <u>JAN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [unclear]</u>			

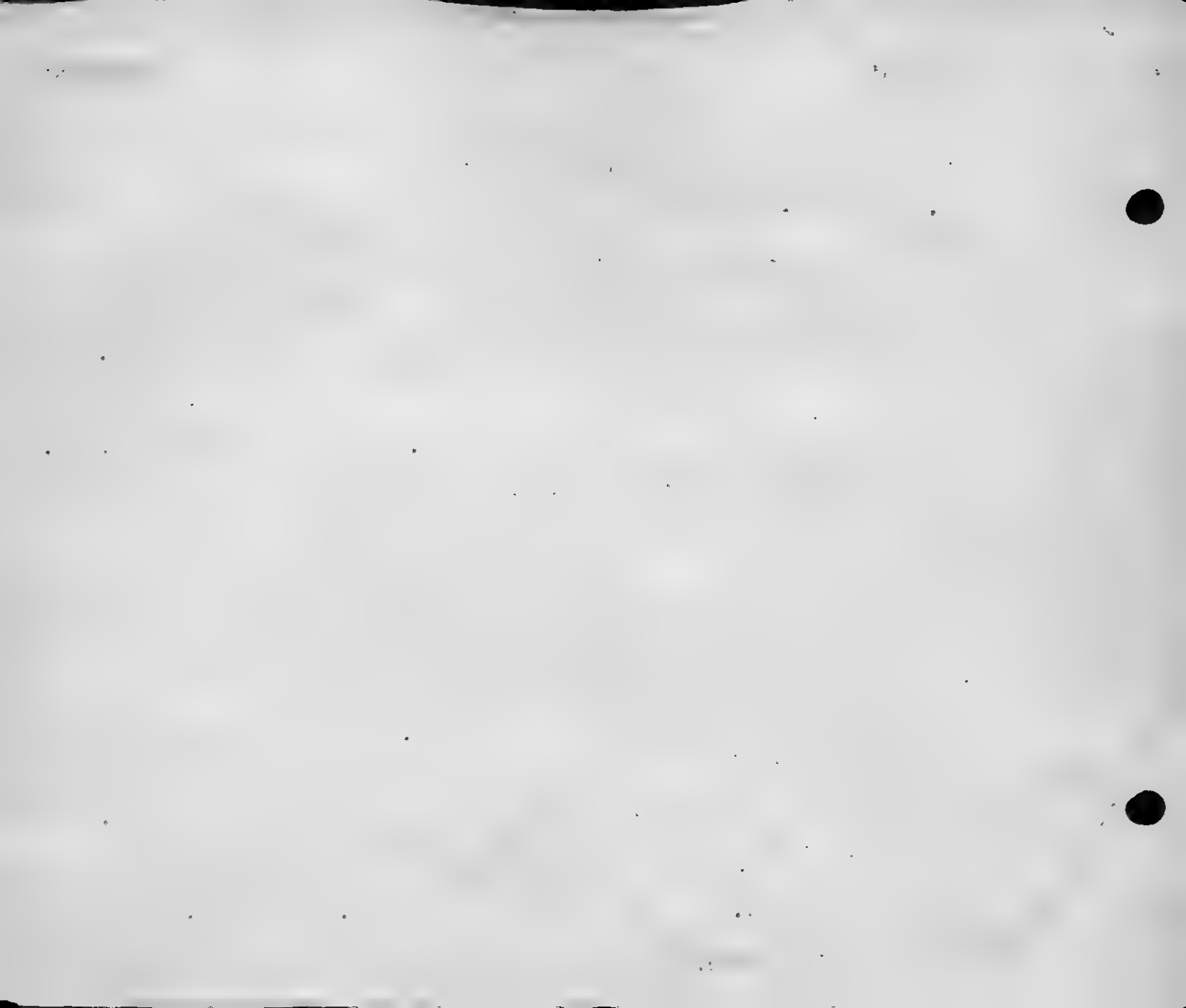
CERTIFICATE OF DEATH

00767

00767

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> c. LENGTH OF STAY IN b. <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kirk Army Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u> d. STREET ADDRESS <u>5 N/ROGERS ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET Irene EMORY</u>		4. DATE OF DEATH Month <u>28</u> Day <u>JAN</u> Year <u>1967</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>24 JULY 80 86</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID BURDUN</u>		14. MOTHER'S MAIDEN NAME <u>MARY O'CONNELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>N/A</u>	
17. INFORMANT <u>Estelle E. Murphy</u>		Address <u>Arlington, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>19 JAN 1967</u> to <u>27 JAN 1967</u> that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u> </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas J. Fraher MD</u>		22b. DATE SIGNED <u>28 Jan. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS J FRAHER</u>		22d. ADDRESS <u>KFH APG MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>31 Jan. 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Arlington, Virginia</u>		23d. LOCATION (City, town or county) (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tarring Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JAN 30 1967</u>	
ADDRESS <u>Aberdeen, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00768					00768				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <i>HARFORD</i> MARYLAND					a. STATE <i>MARYLAND</i> b. COUNTY <i>Cecil</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>HAURE DE GRACE</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Perryville</i>				
c. LENGTH OF STAY IN 1b <i>6 days</i>					d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford Memorial Hosp.</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. IS RESIDENCE ON A FARM?			
First Middle Last <i>ANNA MARGARETTA FADLEY</i>				Month Day Year <i>JANUARY 14 1967</i>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 14 1891</i>		9. AGE (In years last birthday) <i>75</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James Worth</i>				14. MOTHER'S MAIDEN NAME <i>Anna A. Bedford</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mr. Chas. C. Fadley, Perryville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac arrhythmia</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cholecystectomy for emphysema of gall bladder</i>								INTERVAL BETWEEN ONSET AND DEATH <i>7 hr</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-9</i> , 19 <i>67</i> , to <i>1-14</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>1-14</i> , 19 <i>67</i> , and that death occurred at <i>11:45</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Charles J. Foley Jr.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>CHARLES J. FOLEY JR.</i>				22d. ADDRESS <i>HAURE DE GRACE, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>1/17/1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Principio Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Perryville, Cecil Md.</i>			
24. FUNERAL DIRECTOR <i>Sec. J. M. Brown & Son, Perryville, Md.</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE		JAN 23 1967			



FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00769

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00769

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Harford	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c LENGTH OF STAY IN 1b 3 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pulaski Motel U.S. #40		d STREET ADDRESS Shamrock Diner	
3 NAME OF DECEASED (Type or print) First HOWARD Middle ROY Last FIZER		4 DATE OF DEATH Month January Day 1 Year 1967	
5. SEX Male	6 COLOR OR RACE Cau.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12 Jan. 1914
9 AGE (In years last birthday) yrs 52		10 UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurants	
11 BIRTHPLACE (State or foreign country) Martinsburg, W.Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Andrew J. Fizer		14. MOTHER'S MAIDEN NAME Vally May Keys	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-2		16 SOCIAL SECURITY NO 184-05-1564	
17 INFORMANT Elsie Dougan		Address Havre de Grace, Md.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 3 m pm 19 67		20d INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C. Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald C. Palmer M.D.		Address (Street, city, town, or county) Bel Air, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Jan. 4, 1967	
23c NAME OF CEMETERY OR CREMATORY Slateville Cemetery		23d LOCATION (City or Town) (County) (State) Delta York Penna.	
24 FUNERAL DIRECTOR John H. Harkins		ADDRESS Delta, Pa.	
25a REC'D BY REGISTRAR DATE JAN 4 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00770

00770

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN ID <u>8 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margary Bell Harvey</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 2 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 2, 1936</u>	9. AGE (In years last birthday) <u>30</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas & Elct. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Utility Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clyde Worrell Harvey</u>				14. MOTHER'S MAIDEN NAME <u>AUNE BELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-26-6475</u>		17. INFORMANT (Father) <u>838-4746</u> Address <u>Mr. Clyde W. Harvey 363 Catherine St. Bel Air, Md. 21014</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage, rt. temporal</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1, 1967</u> to <u>JAN 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN 2, 1967</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>Jan 2, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				22d. ADDRESS <u>Harford Memorial Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>JAN 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cath. Ch. Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Hickory, Harford Co. Maryland</u>				
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>				25a. REC'D BY REGISTRAR <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00771

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm.ssion) a. STATE <u>Pa.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kennedy Hwy. - Mr. White. Mark</u>		d. STREET ADDRESS <u>2503 W. Thompson St</u>	
3 NAME OF DECEASED (Type or print) <u>Mapine Hewlett</u>		4 DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Colored</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/20/45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sorter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philco Corp.</u>	9 AGE (In years last birthday) <u>21</u> yrs
11 BIRTHPLACE (State or foreign country) <u>Philadelphia Pennsylvania U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Richard Hewlett</u>		14. MOTHER'S MAIDEN NAME <u>Ann Thones</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17 INFORMANT <u>Hobson Reynolds</u>		Address <u>Philadelphia, Penn.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <u>Multiple Injuries</u> IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Multiple Injuries</u> DUE TO (c)			INTERVA. BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto - into fixed object</u>	
20c. TIME OF INJURY Month, Day, Year Hour o m <u>4:46 PM 1-21-1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Street</u>
20f. (City or town) <u>Hartford Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Werner U. Spitz</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WERNER U. SPITZ, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1.21.67</u>	
22. DATE SIGNED		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Philadelphia, Penna.</u>
24 FUNERAL DIRECTOR <u>Hobson Reynolds - 2042-44 Ridge Ave., Phila. Pa.</u>		25a. REC'D BY REGISTRAR <u>25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00772						00772							
1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>				c. LENGTH OF STAY IN ID <u>9 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forrest Hill</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>						d. STREET ADDRESS <u>Tarrettsville Pike</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Holloway</u>			4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Nov. 10, 1961</u>			9. AGE (in years last birthday) <u>5</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>18</u> Hours <u>18</u> Min. <u>00</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>HAURE DE GRACE, MD.</u>					
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Holloway, BILL</u>				14. MOTHER'S MAIDEN NAME. <u>Gibbs, Grace</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>1</u>				17. INFORMANT Address <u>William Holloway, Forrest Hill, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidosis, Meningitis, pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Consulting surgeon & cardiac arrest</u> (c) <u>Bilateral Bronchopneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u> <u>30 hrs</u>													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1-18, 1967</u> to <u>1-18, 1967</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:47</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>[Signature]</u>												22b. DATE SIGNED <u>1/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. RALPH HOKKY</u>												22d. ADDRESS <u>CHURCHVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JAN. 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WELCOME HOME</u>				23d. LOCATION (City, town or county) (State) <u>HICKORY, HARTFORD CO., MD.</u>			
24. FUNERAL DIRECTOR <u>John H. Harbison, DELTA, Pa.</u>						25a. REC'D BY REGISTRAR <u>JAN 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00773

CERTIFICATE OF DEATH

00773

1. PLACE OF DEATH a. COUNTY Harford, Aberdeen MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Prov. Gd		c. LENGTH OF STAY IN lb 16 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2728-D West Ct., AFG, Maryland		d. STREET ADDRESS AFG, Aberdeen, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willia Middle Mae Last Hudson		4. DATE OF DEATH Month Jan Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Feb 1899
9. AGE (in years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work on 16, even if retired) Housewife Teacher		10b. KIND OF BUSINESS OR INDUSTRY Home School	
11. BIRTHPLACE (County & State, or foreign country) San Antonio, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harford: Unknown		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 527-24-0657D	
17. INFORMANT LTC. Albert Justice		Address (same as above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Liver Carcinoma DUE TO (c) Metastasis		INTERVAL BETWEEN ONSET AND DEATH 2 Days 2 Years 2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 3:20 Hour a.m. 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 Nov , 19 67 , to 8 Jan , 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 8 Jan , 19 67 , and that death occurred at 0320aM , from causes and on the date stated above			
22a. SIGNATURE John L. Butsch		22b. DATE SIGNED 8 Jan. '67	
22c. PHYSICIAN'S NAME (Type) JOHN L. BUTSCH, CPT., MC		22d. ADDRESS 413 Haslett Rd., Joppatowne, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11 Jan. 67	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City or Town) (County) (State) Tucson, Arizona	
24. FUNERAL DIRECTOR Tarring		25a. REC'D BY REGISTRAR JAN 11 1967	
25b. REGISTRY SIGNATURE Judge		25c. ADDRESS Aberdeen, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

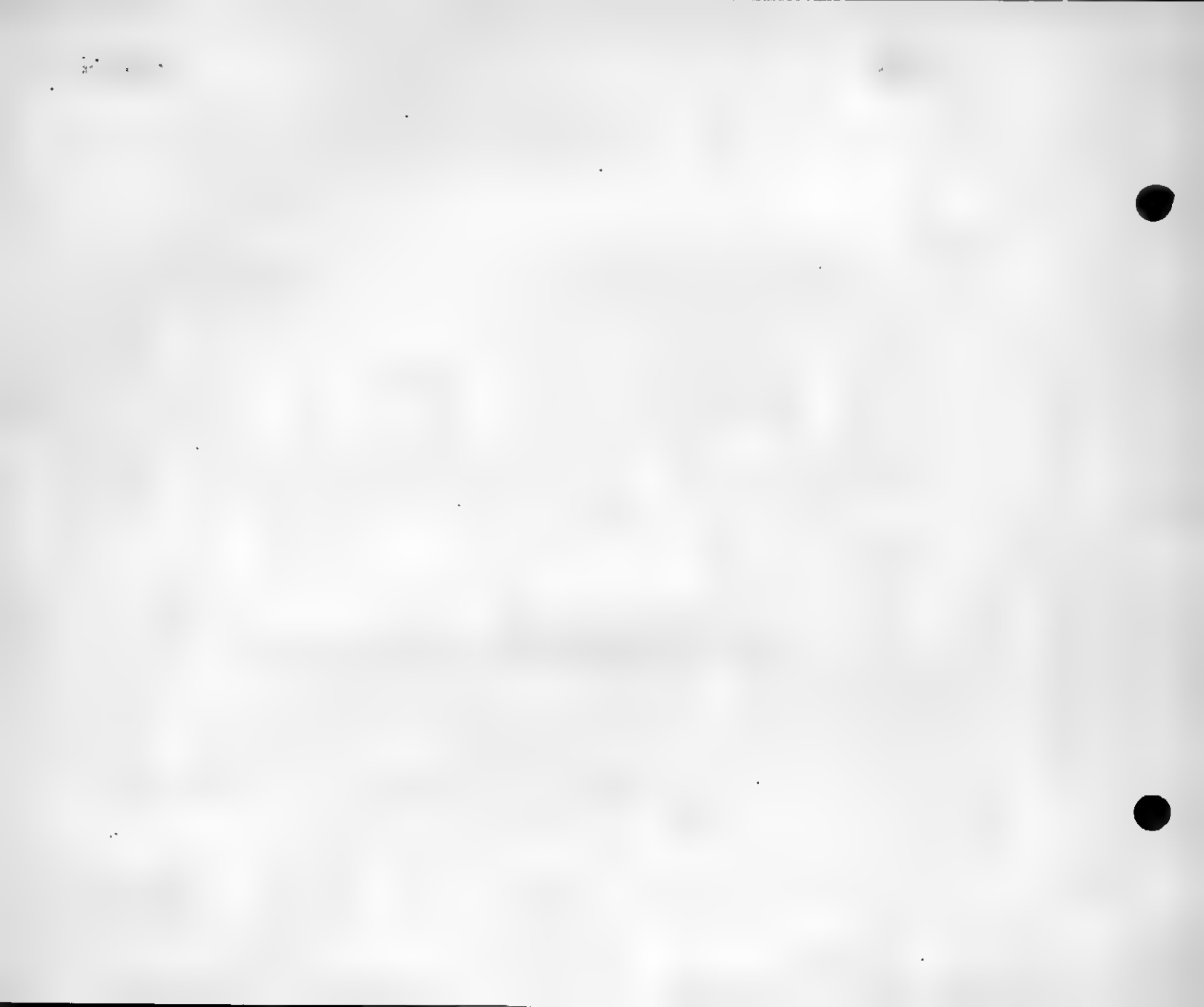
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

202

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00774 CERTIFICATE OF DEATH 00774

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>RD 2; Thomas Run Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN Johnson</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 18 1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1896</u>		9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>70 yrs.</u> Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.P. Ground</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Johnson</u>				14. MOTHER'S MAIDEN NAME <u>No record</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-18-4038</u>		17. INFORMANT Address <u>Mrs. Bertha P. Murray, Bel-Air, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>13X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u>Hypertensive - Arteriosclerotic Heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Urinary Tract Infection</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>11</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 30, 1966</u> , to <u>JAN 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 18, 1967</u> , and that death occurred at <u>6:55</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>George T. Stansbury,</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury,</u>				22d. ADDRESS <u>569 Revolution St. Haverde Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-22-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Methodist Cem</u>		23d. LOCATION (City, town or county) (State) <u>Churchville Harford Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Elmer W. Hall</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>Haverde Grace, Md</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>JAN 23 1967</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00775

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00775

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Level Rd. Rd 2</u>		d. STREET ADDRESS <u>Box 267 Westwood Manor Farm Old Level Road</u>	
3 NAME OF DECEASED (Type or print) <u>Jessica Mae Johnson</u>		4 DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>E</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-8-66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JESSIE James Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Curton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Jessie James Johnson Churchville MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Significant due to injured</u> <u>1219</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Vomitus</u> DUE TO (c) <u>SD 11</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>1-5-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-7-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Berkley</u>		23d. LOCATION (City or Town) (County) (State) <u>Darlington Hartford MD</u>	
24. FUNERAL DIRECTOR <u>George W TITTLE</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 10 1967</u>	
ADDRESS <u>BEL AIR MD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, see page 1, 2, and 3 to the form for the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

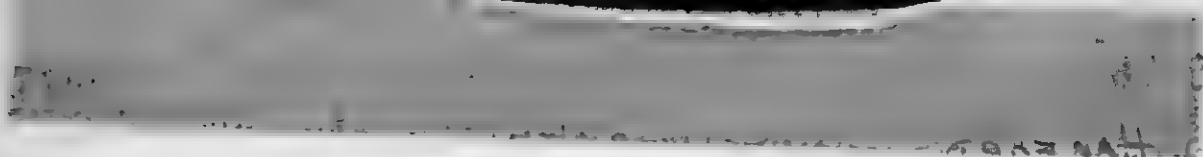
00776

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00776

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Who is deceased? a. and b. Insist on Residence before admission) b. STATE MARYLAND c. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST HILL		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 164 - FARM Jarrettsville Road		d. STREET ADDRESS BOX 164 JARRETTSVILLE Rd	
3. NAME OF DECEASED (Type or print) PAUL DONALD JOHNSON		4. DATE OF DEATH JAN 25 1967	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 14, 1924
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY Gen. farming	
11. BIRTHPLACE (State or foreign country) Forest Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Raymond Johnson		14. MOTHER'S MAIDEN NAME Frances Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-18-0522	
17. ADDRESS Box 164 Jarrettsville Rd.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTERNAL HEMORRHAGE CHEST DUE TO (b) CRUSHING BY FARM TRACTOR DUE TO (c) CRUSHING BY FARM TRACTOR	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. FARM TRACTOR ROLLED OVER, SIDE OF HILL	
20c. TIME OF INJURY Month, Day, Year 2:50 p.m. JAN 25 1967		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work FARM	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) FOREST HILL, HARFORD, Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. LOCATION (City, town, or country) BEL AIR, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/1967	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		22d. LOCATION (City, town, or country) Bel Air Maryland	
23. FUNERAL DIRECTOR Charles E. Kurtz		24a. REC'D BY REGISTRAR JAN 27 1967	
24b. REGISTRAR'S SIGNATURE Charles Judge		24c. REGISTRAR'S SIGNATURE Charles Judge	

21084



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00777

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00777

1 PLACE OF DEATH a COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Hartford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Horse Shoe Lane</u>		c LENGTH OF STAY IN b <u>19 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d STREET ADDRESS <u>North Phila. Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>Lillie Ann Jones</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1871</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping help</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.A. Hospital</u>	9 AGE (In years, last birthday) <u>96</u>
11. BIRTHPLACE (State or foreign country) <u>Hartford County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Barney Smith</u>		14. MOTHER'S MAIDEN NAME <u>Amelia McComas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Mr. John Peavy, Stepmother, Aberdeen, Md.</u>		Address <u>Rt. 1 Box 88</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>2nd Degree Burns to Body</u> 9/6.0 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>House fire</u>	
20c. TIME OF INJURY Month Day Year Hour a.m. <u>12-27</u> 19 <u>66</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Aberdeen</u> <u>Harford</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/A i - md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>1-16-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 19, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		23d. LOCATED ON (City or town) (County) (State) <u>Aberdeen</u> <u>Harford Co.</u> <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Philip J. Bullock, Starve de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
ADDRESS <u>56 Remond St.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>JAN 20 1967</u>			

00778

CERTIFICATE OF DEATH

00778

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admision) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Street</u>		c LENGTH OF STAY IN lb <u>57 years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D.#2</u>		d. STREET ADDRESS <u>R.D.#2</u>	
3 NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>MARY</u> Last <u>KOHLBUS</u>		4 DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 25, 1889</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <u>77</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Constitution, Pa.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Flaharty</u>		14 MOTHER'S MAIDEN NAME <u>Ada Orr</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>218-30-6283</u>	
17. INFORMANT <u>Mrs. Paul Iddings, Street, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4/20/11 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Advanced hypertensive arteriosclerotic cardiocase. dis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic pyelonephritis</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>7 Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7 Jan</u> , 19 <u>67</u> , and that death occurred at <u>7:40 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edwin W. Whiteford, Jr.</u>		22b. DATE SIGNED <u>Jan. 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edwin W. Whiteford, Jr.</u>		22d. ADDRESS <u>Whiteford, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Jan. 9, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Emory</u>	23d LOCATION (City or Town) (County) (State) <u>Street Harford Md.</u>
24 FUNERAL DIRECTOR <u>John A. Harkins</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 10 1967</u>	
ADDRESS <u>Delta, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>00779</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>00779</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Har-de-Grace</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>					
c. LENGTH OF STAY IN 1b <u>4 days</u>						d. STREET ADDRESS <u>Star Route Box 133</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Robert Henry Leight</u>						4. DATE OF DEATH <u>JANUARY 25 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 29, 1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John P. Leight</u>						14. MOTHER'S MAIDEN NAME <u>Lavinia Shields</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-05-0033</u>		17. INFORMANT <u>Robert E. Leight, Abingdon, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO <u>A.S.C.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u> <u>E.G.I. leading etiology not certain</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)				20h. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-21, 1967</u> to <u>1-25, 1967</u> , that (I) (we) last saw the deceased alive on <u>1-25, 1967</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward C. Lee</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>1/25/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>						22d. ADDRESS <u>Har-de-Grace, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Abingdon Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u> ADDRESS						25a. REC'D BY REGISTRAR <u>27 1967</u> DATE					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00780

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00780

1 PLACE OF DEATH a. COUNTY <u>Harris</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harris</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harris</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>R.D. #1</u>	
3 NAME OF DECEASED (Type or print) <u>Hollis Lewis</u>		4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 12, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>	9 AGE (In years last birthday) yrs <u>65</u>
11 BIRTHPLACE (State or foreign country) <u>ASHE CO., N.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>NATHAN LEWIS</u>		14. MOTHER'S MAIDEN NAME <u>FRONIE OSBORNE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>302-03-4542</u>	
17 INFORMANT <u>HARVEY LEWIS, DARLINGTON, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>910.3 FRACTURE SKULL</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Stack Lumber fell on him</u>	
20c. TIME OF INJURY Month, Day, Year <u>4</u> <u>1-12</u> 19 <u>67</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Blue Ridge Flooring Co.</u>	20f. (City or town) (County) (State) <u>Darlington</u> <u>Harris</u> <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dwight C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> 22. DATE SIGNED <u>1-13-67</u>	
EXAMINER'S NAME (Type) <u>Dwight C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JAN. 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DUBLIN SOUTHERN</u>	23d. LOCATION (City or Town) (County) (State) <u>DUBLIN, HARRIS CO., MD.</u>
24. FUNERAL DIRECTOR <u>John H. Harkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 17 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00781-1				Item 4 111M 1200 1/24/67 mh				00781			
1. PLACE OF DEATH a. COUNTY <u>Hartford</u>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>Priscilla</u> Last <u>Lingan</u>				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1967</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 29 1879</u>		9. AGE (In years last birthday) <u>87 8/4</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Hartford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Lingan</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Wright</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Margaret Ruth Weaver</u> Address <u>Benson Md</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> <u>11211</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-16-67</u> to <u>1-15-67</u> , that (I) (we) last saw the deceased alive on <u>1-16-67</u> , and that death occurred at <u> </u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Gerard C Palmer</u>				22b. DATE <u>1-16-67</u>				22c. PHYSICIAN'S NAME (Type) <u>Gerard C Palmer MD</u>			
22d. ADDRESS <u>Bel Air Md</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u>				22f. DATE <u>JAN 10 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan 18 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St Johns Catholic</u>			
23d. LOCATION (City, town or county) <u>Long Green</u>				23e. REC'D BY REGISTRAR <u>Charles Judge</u>				23f. DATE <u>JAN 10 1967</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Benson MD</u>				24b. ADDRESS <u> </u>				24c. DATE <u> </u>			

00782

CERTIFICATE OF DEATH

00782

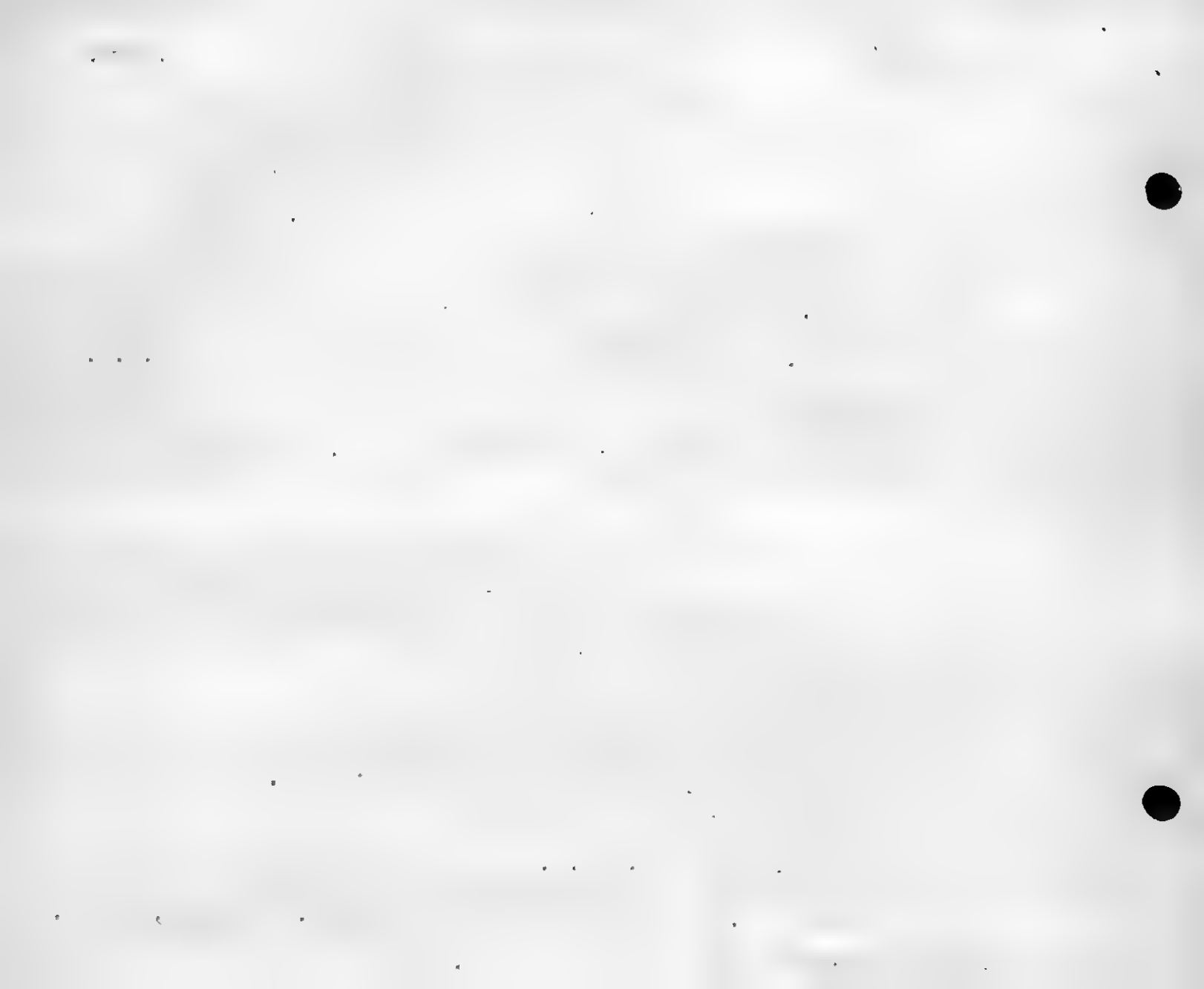
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #2,		d. STREET ADDRESS Route #2, Box 250	
3 NAME OF DECEASED (Type or print) First GEORGE Middle OSCAR Last MAYS		4 DATE OF DEATH Month January Day 7 Year 19 67	
5 SEX Male	6 COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4 March 1886
9 AGE (In years last birthday) yrs 80		10. IF UNDER 1 YEAR Months 26 Days 11 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11 BIRTHPLACE (County & State, or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Mays		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 209-12-5527	
17. INFORMANT Curtis Price, Darlington, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized atherosclerosis + DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 26 hrs 5 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from May 20, 1947 to 1/7, 1967 , that (I) (we) last saw the deceased alive on 1/4, 1967 , and that death occurred at 9:40 PM on causes and on the date stated above.			
22a. SIGNATURE Dudley Phillips		22b. DATE SIGNED 1/8/67	
22c. PHYSICIAN'S NAME (Type) Dudley Phillips, M.D.		22d. ADDRESS Darlington, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10 Jan. 67	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Helen Macomber		25a. REC'D BY REGISTRAR JAN 11 1967	
25b. REGISTERED SIGNATURE Judge		DATE	



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SEVERAL COPIES OF THIS FORM ARE REQUIRED BY THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD 21201

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00783 CERTIFICATE OF DEATH 00783

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 18 months	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brevin Nursing Home		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air	
		f. STREET ADDRESS 2 Lynwood Court	
3. NAME OF DECEASED (Type or print) Margaret Harold McWilliam		4. DATE OF DEATH Month January Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	
11. BIRTHPLACE (County & State, or foreign country) Glasgow, Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Robertson		14. MOTHER'S MAIDEN NAME Hannah Robertson Couborough	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. John R. McWilliam		18. ADDRESS 2 Lynwood Court Bel Air, Md. 21014	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Inanition (2) bronchopneumonia 45000 DUE TO (b) generalized arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH (1) 6 wks (2) 2 mks > 5 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture R. hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 3, 1965 to January 18, 1967 , that (I) (we) last saw the deceased alive on Jan 17, 1967 , and that death occurred at 10:06 P.M. on the causes and on the date stated above.			
22a. SIGNATURE B. J. Plunkett, Jr.		22b. DATE SIGNED Jan. 19, 1967	
22c. PHYSICIAN'S NAME (Type) Barry J. Plunkett, Jr. M.D.		22d. ADDRESS 617 W. Bel Air Ave. Aberdeen, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town or county) (State) Fall River, Mass.
24. FUNERAL DIRECTOR Joseph William Foster		25a. REC'D BY REGISTRAR W. Broadway Williams & Bel Air, Maryland 21014	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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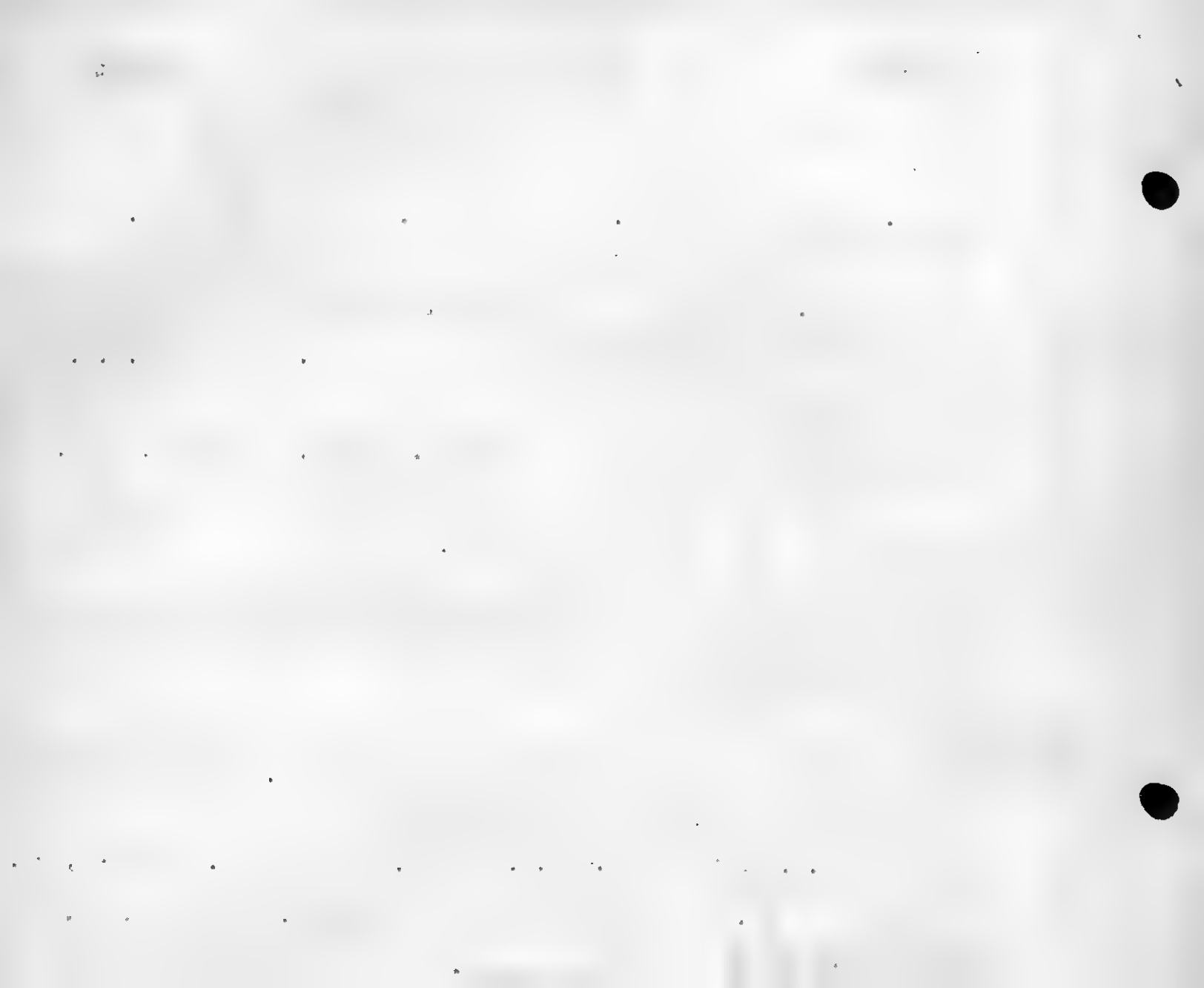
CERTIFICATE OF DEATH

00784

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN lb 12.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 128 N. Philadelphia Blvd.		d. STREET ADDRESS 128 N. Philadelphia Blvd.	
3 NAME OF DECEASED (Type or print) First BEATRICE Middle LONG Last MILLER		4. DATE OF DEATH Month January Day 2 Year 19 67	
5 SEX Female	6 COLOR OR RACE Cau.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 April 1912
9 AGE (In years last birthday) 54 yrs		10. FUNERAL 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Long		14 MOTHER'S MAIDEN NAME Myrtle Simpson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Ralph J. Miller, Aberdeen, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pulmonary edema DUE TO 4.0.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 3 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) pyelonephritis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-26-66 , 19 to 1-2-67 , 19, that (I) (we) last saw the deceased alive on 1-2-67 19 and that death occurred at 1:40 AM from causes and on the date stated above.			
22a. SIGNATURE B. J. Plunkett Jr. M.D.		22b. DATE SIGNED 1-2-67	
22c. PHYSICIAN'S NAME (Type) B. J. Plunkett Jr. M.D.		22d. ADDRESS 617 W. Bel Air Ave. Aberdeen, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 4 Jan. 67	23c. NAME OF CEMETERY OR CREMATORY St Paul Lutheran Cemetery, Aberdeen, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Wesley McCowen Jr.		25a. REC'D BY REGISTRAR Tarring Funeral Home Aberdeen, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 6 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00785				CERTIFICATE OF DEATH				00785			
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>						d. STREET ADDRESS <u>24 N. Phila. Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>MARIE</u> Last <u>Miller</u>						4. DATE OF DEATH Month <u>JANUARY</u> Day <u>14</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 Dec. 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Oberdorffer</u>						14. MOTHER'S MAIDEN NAME <u>Amelia Leeblein</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-48-6569</u>		17. INFORMANT Address <u>Katherine M. Peery, Aberdeen, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Suppurative Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 12, 1967</u> to <u>JAN. 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN. 14, 1967</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Mahmud M. Ishak</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 14, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. W. ISHAK, M.D.</u>						22d. ADDRESS <u>Havre de Grace, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>17 Jan. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Havre de Grace, Maryland</u>			
24. FUNERAL DIRECTOR <u>John A. Harrison</u>						ADDRESS <u>Tarring Funeral Home, Aberdeen, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John A. Harrison</u>	

00786

CERTIFICATE OF DEATH

00786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> d. STREET ADDRESS <u>P.O. Box 184</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thelma</u> Middle <u>Whitney</u> Last <u>Minster</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PHOTO SHOP</u>	11. BIRTHPLACE (County & State, or foreign country) <u>HAVRE DE GRACE, MD.</u>
13. FATHER'S NAME <u>HARRY C. WHITNEY</u>		14. MOTHER'S MAIDEN NAME <u>SADIE EDMONDSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <u>JACOB T. MINSTER</u>		Address <u>HAVRE DE GRACE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage & encephalopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholic cirrhosis & Ammonia Intoxication</u> (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-10</u> , 1967, to <u>1-21</u> , 1967, that (I) (we) last saw the deceased alive on <u>1-21</u> , 1967, and that death occurred at <u>1:50 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles Griguleit</u>		22b. DATE SIGNED <u>1/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. GRIGULEIT</u>		22d. ADDRESS <u>HAVRE DE GRACE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BILPIN MAJOR MEM. PK.</u>	23d. LOCATION (City, town or county) (State) <u>ELKTON, MD.</u>
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 24 1967</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

00787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00787

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Darlington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <u>MARYLAND V.</u> Middle <u>Murphy</u> Last <u>Murphy</u>		4 DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 3, 1910</u>
9 AGE (in years last birthday) <u>56</u> yrs		10 IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>12</u> Min <u>12</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>CONOWINGO, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>ESTIL ROOP</u>		14 MOTHER'S MAIDEN NAME <u>AUGUSTA GRIEST</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>JOHN C. MURPHY, JR., DARLINGTON, Md.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd degree burns entire body</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Burned in house fire</u>	
20c TIME OF INJURY Month, Day, Year <u>12-15-1967</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>	20f (City or town) (County) (State) <u>Darlington Md</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 1-5-67	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Boack, W</u>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>1-7-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>	23d LOCATION (City or Town) (County) (State) <u>DARLINGTON, Md.</u>
24 FUNERAL DIRECTOR <u>John H. Hashima</u>		ADDRESS <u>DELTA, Pa.</u>	
25a REC'D BY REGISTRAR DATE <u>JAN 9 1967</u>		25b REGISTRAR'S SIGNATURE <u>Boack, W</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00788

CERTIFICATE OF DEATH

00788

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
f. STREET ADDRESS <u>14 N. Williams St.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Madeleine</u> Last <u>O'Neill</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1888</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. FUNERAL 1 YEAR <input type="checkbox"/> FUNERAL 24 HRS. <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <u>Hartford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>			
13. FATHER'S NAME <u>Thomas Hall Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Clara Cain</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>213-46-3966</u>		17. INFORMANT (Full name) <u>Mr. Harry St. A. O'Neill</u> Address <u>1 Wall Street Bel Air, Md. 21014</u>	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive + Arteriosclerotic</u> -DUE TO (c) <u>Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia and peripheral arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3-4 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 19th, 1967</u> to <u>Jan. 23, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan. 23rd 1967</u> and that death occurred at <u>12:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>1/23/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				22d. ADDRESS <u>Havre de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>3801 Federal Ave. Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>JAN 25 1967</u>		25b. REGISTRAR'S SIGNATURE	

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00789					00789				
1. PLACE OF DEATH a. COUNTY <i>HARFORD</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harford</i> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>HARFORD Memorial Hospital</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>HARFORD</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i> d. STREET ADDRESS <i>2112 Trimble Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Christine</i> First Middle Last 4. DATE OF DEATH <i>JANUARY 9 1967</i> Month Day Year					5. SEX <i>F</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>					11. BIRTHPLACE (County & State, or foreign country) <i>Md</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>Henry Neumeister</i>					14. MOTHER'S MAIDEN NAME <i>Louise Knoblock</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <i>216-48-1054</i>				
17. INFORMANT <i>Mrs. Wm. Fertig</i> Address <i>2112 Trimble Road, Edgewood</i> Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221 Acute cardiac failure due to severe gene. ASCVD.</i> DUE TO (b) <i>Acute & Chronic Illness.</i> DUE TO (c) <i>Megacolon - megarectum.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Megacolon - megarectum.</i>								INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days (General med)</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1-9-1967</i> , to <i>1-9-1967</i> , that (I) (we) last saw the deceased alive on <i>1-9-1967</i> , and that death occurred at <i>11:00</i> M., from the causes and on the date stated above.									
22a. SIGNATURE <i>Henry H. Kwak</i> 22c. PHYSICIAN'S NAME (Type) <i>HENRY H. KWAK</i>					22b. DATE SIGNED 22d. ADDRESS <i>608 S. Union Ave. Harford Md</i>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Jan. 12, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>		23d. LOCATION (City, town or county) (State) <i>Bel Air Harford Md</i>		
24. FUNERAL DIRECTOR <i>Howard K. McComas & Son,</i> ADDRESS <i>Abingdon, Md.</i>					25a. REC'D BY REGISTRAR <i>JAN 12 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00790

1 PLACE OF DEATH a COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, 1 inst tuition Residence before admission) a STATE <u>MD</u> b COUNTY <u>HARFORD</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		d STREET ADDRESS <u>324 N Union Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>Estelle</u> Last <u>PAIR</u>		4 DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>NOV. 25, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9 AGE (n years last birthday) <u>86</u> yrs
11 BIRTHPLACE (State or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SILAS S. WHITELOCK</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN STANDIFORD</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16 SOCIAL SECURITY NO <u>216-24-7026</u>	
17 INFORMANT <u>EDWARD S. WARD</u>		<u>7834 ST. BRIDGES LANE DUNDALK, MD 21222</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Femur</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <u>—</u>			19 WAS A JTOPTYP PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell</u>	
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.) <u>Beverly Nursing Home</u>		20f. (City or town) (County) (State) <u>HARFORD MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-6-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN. 8, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		23d. LOCATION (City or town) (County) (State) <u>HARFORD MD.</u>	
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		25a. REC'D BY REGISTRAR <u>JAN 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00791		Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000									
1. PLACE OF DEATH a. COUNTY <i>Hartford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Hartford</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>35 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hartford Memorial</i>		d. STREET ADDRESS <i>119 Market St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Margaret</i> Last <i>Patrick</i>		4. DATE OF DEATH Month <i>1</i> Day <i>8</i> Year <i>1967</i>									
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/4/1894</i>	9. AGE (In years last birthday) <i>72</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>MD</i>							
13. FATHER'S NAME <i>James Kelly</i>		14. MOTHER'S MAIDEN NAME <i>Mary Kelly</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>hub</i>		17. INFORMANT <i>Howard Bullock</i> Address <i>600 Market St. Havre de Grace, Md</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVA - Cerebral thrombosis</i> DUE TO (b) <i>Hypertension ASHD</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Blonding pneumonia Hypotonic</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> , to <i>1967</i> , that (I) (we) last saw the deceased alive on <i>1/4/67</i> , and that death occurred at <i>9:26</i> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Santiago Leyte-Vidal</i>		22b. DATE SIGNED <i>1-8-66</i>									
22c. PHYSICIAN'S NAME (Type) <i>SANTIAGO LEYTE-VISAL</i>		22d. ADDRESS <i>114 W. BEL AIR AVE.</i>									
23a. (BURIAL, CREMATION, REMOVAL) (Specify) <i>1/4/67</i>		23b. DATE THEREOF <i>1/4/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hartford Mem. Gardens</i>							
23d. LOCATION (City, town or county) (State) <i>Aldino Md</i>											
24. FUNERAL DIRECTOR <i>Funeral Home, Havre de Grace, Md.</i>		25a. REC'D BY REGISTRAR <i>—</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00792

CERTIFICATE OF DEATH

00792

1 PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Long Bar Harbor		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon	
3 NAME OF DECEASED (Type or print) First FLORENCE Middle ESTELLE Last RATCLIFFE		4. DATE OF DEATH Month JANUARY Day 2 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 26, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Burns Ratcliffe		14. MOTHER'S MAIDEN NAME Florence Hoffner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 220-44-6007	
17 INFORMANT Donald B. Ratcliffe, 917 Army Road, Towson 4		Address Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 199.2 IMMEDIATE CAUSE (a) Carcinomatosis in abdomen DUE TO (b) Primary lesion - not known Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility and A.S.C.V.D.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 20, 1966 to Jan. 2, 1967 that (I) (we) last saw the deceased alive on Jan. 2nd 1967 , and that death occurred at 5 P.M. from causes and on the date stated above.			
22a. SIGNATURE Edward Loo, M.D.		22b. DATE SIGNED Jan. 2nd '67	
22c. PHYSICIAN'S NAME (Type) Edward Loo, M.D.		22d. ADDRESS 211 N. Union Ave., Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24 FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		25a. REC'D BY REGISTRAR JAN 4 1967	
		25b. REGISTRAR'S SIGNATURE W. J. Judge	

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<div style="display: flex; justify-content: space-between;"> <div> <div>1</div> <div>00793</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>00793</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Md</u> c. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>						c. LENGTH OF STAY IN 1b <u>7 hours</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>						d. STREET ADDRESS <u>1107 Mountain Rd.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Talmage Samuel Richardson</u>						4. DATE OF DEATH Month Day Year <u>January 22 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1906</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W. Jefferson, North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jonah Richardson</u>						14. MOTHER'S MAIDEN NAME <u>Leona Roberts</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-18-0259</u>		17. INFORMANT Address <u>Baltimore, Md.</u> <u>Mr. Jerrel Richardson, 20B Cedar Drive,</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Catastrophic myocardial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Rupture of the myocardium</u> (c) <u>by atherosclerotic infarction</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>January 22, 1967</u> to <u>January 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 22, 1967</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Jan. 23, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lajos Mezei</u>						22d. ADDRESS <u>Havre de Grace, Harford Co., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air Harford Md</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>						25a. REC'D BY REGISTRAR DATE <u>JAN 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



00794

CERTIFICATE OF DEATH

00794

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		c. LENGTH OF STAY IN lb 82 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Ross		4. DATE OF DEATH Month January Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1884
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Harford Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Parry	
14. MOTHER'S MAIDEN NAME Carrie Stull		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mabel Love Address Delta, R.D., Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Caroline Deconspensation 4/22/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arterio Sclerotic C-V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1950 , to Jan 27, 1967 , that (I) (we) last saw the deceased alive on Jan 37, 1967 , and that death occurred at 3A M from causes and on the date stated above.			
22a. SIGNATURE Josiah A. Hunt		22b. DATE SIGNED 1/28/67	
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.		22d. ADDRESS Delta, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF Jan. 29, 1967	23c. NAME OF CEMETERY OR CREMATORY State Ridge	23d. LOCATION (City or Town) (County) (State) Delta, York Co., Pa.
24. FUNERAL DIRECTOR John H. Hawkins		25a. REC'D BY REGISTRAR JAN 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00795

CERTIFICATE OF DEATH

00795

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
c. LENGTH OF STAY IN 1b <u>10.0.0</u>		d. STREET ADDRESS <u>610 Erie ST</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theodore Lewis Sprouse</u>		4. DATE OF DEATH <u>1</u> <u>28</u> <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/30/1913</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Roseland Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry F. Sprouse</u>		14. MOTHER'S MAIDEN NAME <u>Katie Davidson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Bernard Sprouse</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Carditis</u> DUE TO (c) <u>Arteriosclerotic Heart disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 1962, to <u>1/28</u> , 1967, that (I) (we) last saw the deceased alive on <u>1/26</u> , 1967, and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED <u>1/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>569 Revolution St. Harre-de-Grace, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>2/1/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City, town or county) (State) <u>Harre-de-Grace Md.</u>	
24. FUNERAL DIRECTOR <u> </u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00796 CERTIFICATE OF DEATH 00796											
1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de-Grace</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Ford</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>						d. STREET ADDRESS <u>Rt. 1, Box 144</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Eustine Joann Strawbridge</u>						4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/21/1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House - wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Morris</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Fake</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>M.F. Strawbridge, Whiteford, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular thrombosis massive</u> DUE TO (b) <u>Generalized atherosclerotic</u> DUE TO (c) <u>Cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2nd, 1967</u> to <u>Jan 6, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan. 6th 1967</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward C. Lee, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>1/6/1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>						22d. ADDRESS <u>Hartford de Grace Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Pylesville, Hartford Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Stewarttown</u>						ADDRESS <u>Stewarttown, Penna</u>			25a. REC'D BY REGISTRAR <u>JAN 11 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

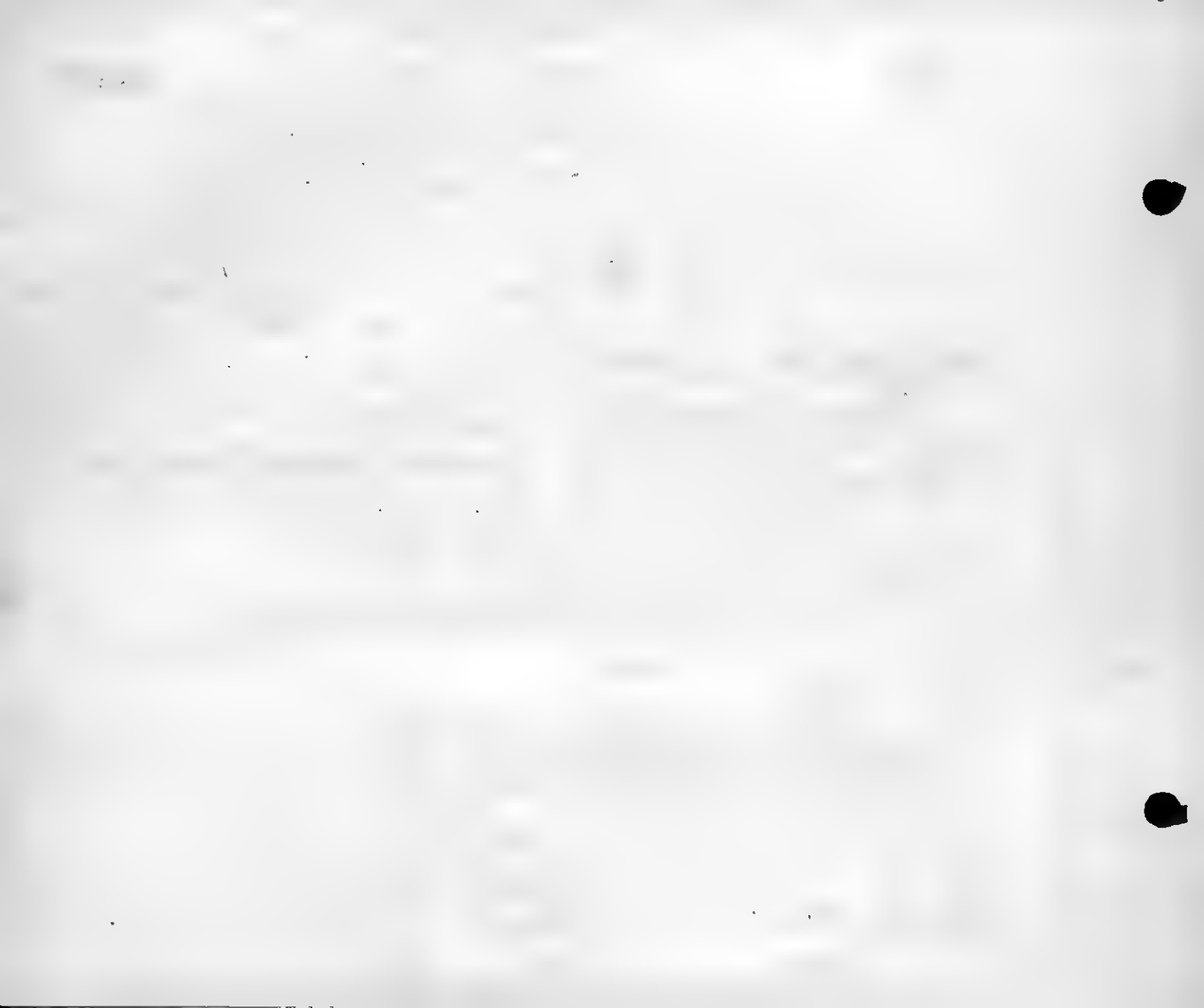
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00797

CERTIFICATE OF DEATH

00797

1 PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD		c. LENGTH OF STAY IN 1b 2 MONTHS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BREVIN NURSING HOME		d. STREET ADDRESS STREET	
3 NAME OF DECEASED (Type or print) First EDITH Middle R. Last TREAKE		4 DATE OF DEATH Month 1 Day 5 Year 1967	
5 SEX F	6 COLOR OR RACE WH	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 83 yrs.
11 BIRTHPLACE (County & State, or foreign country) HARFORD MD		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BASIL TREAKE		14. MOTHER'S MAIDEN NAME SARAH E. HUFF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO ---	
17. INFORMANT Mrs. ELA SCARFF, BELAIR, MD.		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) possibly heart attack DUE TO (found dead in bed) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last A.S.C.V.D. (b) --- DUE TO --- (c) ---		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 25, 1966 to 1-3, 1967 that (I) (we) last saw the deceased alive on 1-3, 1967 , and that death occurred at 3A.M. from causes and on the date stated above.			
22a. SIGNATURE John D. Yum		22b. DATE SIGNED 1/5/67	22c. ADDRESS HAURA de GRACE MD
22c. PHYSICIAN'S NAME (Type) JOHN D. YUM		22d. ADDRESS HAURA de GRACE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JAN. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY EMORY	23d. LOCATION (City or Town) (County) (State) STREET, HARFORD, MD.
24. FUNERAL DIRECTOR John H. Harkin, DELTA, PA.		25a. REC'D BY REGISTRAR JAN 10 1967	
25b. REGISTRAR'S SIGNATURE ---		25c. REGISTRAR'S SIGNATURE ---	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00643

1 PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE UNKNOWN b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FALLSTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp., give street address) along State route #152 near Kidd Road		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) Unknown Newborn Male		4 DATE OF DEATH Pronounced Month January Day 26 Year 1967	
5 SEX Male	6 COLOR OR RACE ?	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b AGE (In years lost birthday) Yrs 1 Months 26 Days 67 Hours 19 Min.	
10a KND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)	
12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME UNKNOWN	
14 MOTHER'S MAIDEN NAME UNKNOWN		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO.		17 INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Head injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18) Abandonment of the newborn, found beside road	
20c TIME OF INJURY Month, Day, Year Hour a.m. Unknown 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f (City or town) (County) (State) Fallston, Harford, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7/24/67	
23c. NAME OF CEMETERY OR CREMATORY MORRIS		23d. LOCATION (City or town) (County) (State) Fallston, Harford, Maryland	
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR JUL 25 1967	
25b REGISTRAR'S SIGNATURE Charles S. Springate			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00798

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00798

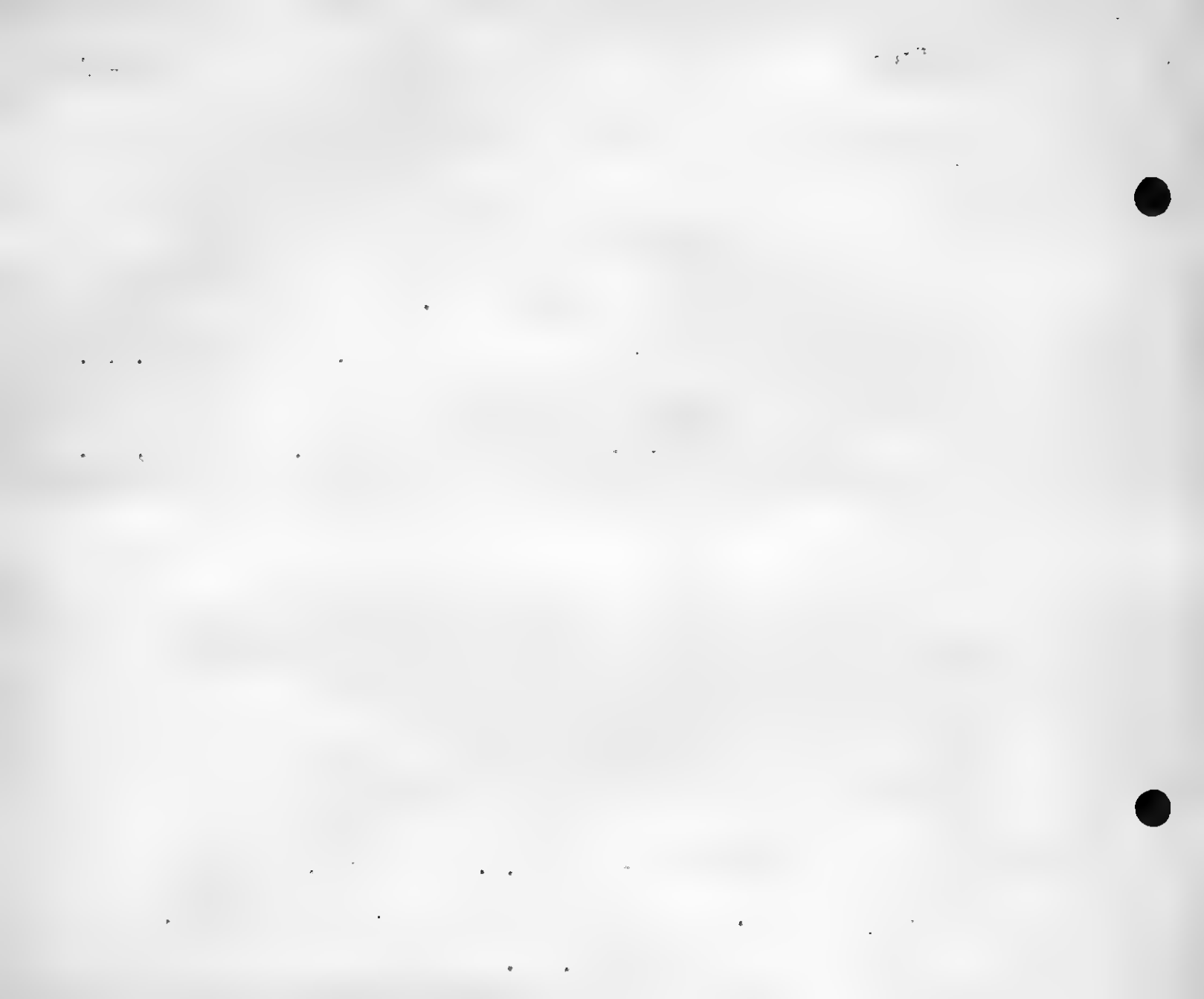
1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Revolution Street	
3 NAME OF DECEASED (Type or print) WARREN S. MATANABE		4 DATE OF DEATH Month January Day 23 Year 19 67	
5 SEX Male	6 COLOR OR RACE Hawaiian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/21/1928
9. AGE (In years lost birthday) 38 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Hawaii		12. CT. ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilfred Matanabe		14. MOTHER'S MAIDEN NAME Rhigae Tanaka	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WW 2		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Indira Watanabe		Address 66 Revolution St. Harford, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. 914.3 IMMEDIATE CAUSE (a) Electrocution. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Head came in contact with bare wire.	
20c. TIME OF INJURY Month, Day, Year Hour 2:30 pm 1/23 19 67		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Laundry		20f. (City or town) (County) (State) Havre de Grace Harford Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		22. DATE SIGNED 1/24/67	
EXAMINER'S NAME (Type) Charles S. Petty		22. DATE SIGNED 1/24/67	
23a. BURIAL (CREMATION, REMOVAL) (Specify) Burial		23b. DATE THEREOF 1/27/67	
23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR William R. Hance		25a. REC'D BY REG. STRAR Charles Judge	
ADDRESS Harford, Md.		25b. REG. STRAR'S SIGNATURE Charles Judge	
DATE JAN 27 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00799						00799					
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN lb <u>26 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>						d. STREET ADDRESS <u>1 EAST INCA</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last						4. DATE OF DEATH <u>JANUARY 20</u> 19 <u>67</u> Month Day Year					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 Dec. 1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Portsmouth, Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph C. Ovorman</u>						14. MOTHER'S MAIDEN NAME <u>Nellie Bassett</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-38-4572</u>		17. INFORMANT <u>Nellie Tomlinson, Aberdeen, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANAPLASTIC CARCINOMA</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-26, 1966</u> to <u>1-20, 1967</u> , that (I) (we) last saw the deceased alive on <u>1-20, 1967</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Santiago Leyte-Vidal</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-20-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Santiago Leyte-Vidal M.D.</u>						22d. ADDRESS <u>Aberdeen, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>22 Jan. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Gardens</u>				23d. LOCATION (City, town or county) (State) <u>Aberdeen, Maryland</u>			
24. FUNERAL DIRECTOR <u>Walter Macomber Jr.</u>						ADDRESS <u>Aberdeen, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00800

CERTIFICATE OF DEATH

00800

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u> c. LENGTH OF STAY IN 1b <u>5th day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Colora</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Welby Owen White</u>			4. DATE OF DEATH Month Day Year <u>JANUARY 17 1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 31 1902</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper Ret. Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Casey Creek Ky.</u>			
13. FATHER'S NAME <u>Merton Everett White</u>			14. MOTHER'S MAIDEN NAME <u>ALTONA Wolzord</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-22-6527R</u>		17. INFORMANT <u>Mrs Welby White</u> Address <u>Colora Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of Lungs</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 13, 1967</u> to <u>JAN 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN 17 1967</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dudley Phillips MD</u>			22b. DATE SIGNED <u>1/17/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		
22d. ADDRESS <u>DARLINGTON MD</u>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-19-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Bridge Baptist</u>	23d. LOCATION (City, town or county) <u>Rising Sun Cecil Md.</u>	(State)			
23e. FUNERAL DIRECTOR <u>Ermon M. Mullen</u>			23f. ADDRESS <u>Rising Sun Md</u>				
25a. REC'D BY REGISTRAR <u>JAN 19 1967</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

00801

CERTIFICATE OF DEATH

00801

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE c. LENGTH OF STAY IN b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 133 WEBER ST.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE d. STREET ADDRESS 133 WEBER ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORENCE CALVA WIEMERT		4. DATE OF DEATH Month JAN. Day 6 Year 1967	
5. SEX FEMALE	6. COLOR OF RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 16, 1896
9. AGE (in years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10	11. IF UNDER 24 HRS. Hours 10 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EARNEST HAYS GIBSON		14. MOTHER'S MAIDEN NAME MARY ELIZABETH HACKNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-56-1129	
17. INFORMANT FREDERICK H. WIEMERT		Address HAVRE DE GRACE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Diabetes mellitus (2) Acute gastritis INTERVAL BETWEEN ONSET AND DEATH Sudden 6-7 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1967 to Jan. 6th, 1967 , that (I) (we) last saw the deceased alive on Jan. 6th, 1967 , and that death occurred at 9p.m. from the causes and on the date stated above			
22a. SIGNATURE Edward C. Loo, M.D.		22b. DATE SIGNED 1/9/67	
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22d. ADDRESS Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 9 1967	
23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d. LOCATION (City, town or county) (State) HAVRE DE GRACE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE R. Maduise Mitchell		25a. REC'D BY REGISTRAR Jan 10 1967	
25b. REGISTRAR'S SIGNATURE J. J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

VR A15 (4)
15M 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>00802</p> </div> <div style="text-align: center;"> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>00802</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Harford</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>Md</u> b. COUNTY <u>Harford</u></p>					
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><u>Have de Grace</u></p>				<p>c. LENGTH OF STAY IN 1b</p> <p><u>1</u> days</p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><u>Churchville</u></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p><u>Harford Memorial Hospital</u></p>				<p>d. STREET ADDRESS</p> <p><u>Calvary Road</u></p>				<p>e. IS RESIDENCE ON A FARM?</p> <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p>First Middle Last <u>LAURA MAE Wilmoth</u></p>				<p>DATE OF DEATH</p> <p>Month Day Year <u>JANUARY 4 1967</u></p>					
<p>5. SEX</p> <p><u>Female</u></p>		<p>6. COLOR OR RACE</p> <p><u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p><u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p><u>3 Dec. 1892</u></p>		<p>9. AGE (in years last birthday)</p> <p><u>74</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Housewife</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p><u>Home</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country)</p> <p><u>Virginia</u></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><u>U.S.A.</u></p>	
<p>13. FATHER'S NAME</p> <p><u>Unknown</u></p>				<p>14. MOTHER'S MAIDEN NAME</p> <p><u>Unknown</u></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</p> <p><u>No</u></p>				<p>16. SOCIAL SECURITY NO. (If yes give war or dates of service)</p> <p><u>229-48-3056</u></p>		<p>17. INFORMANT Address</p> <p><u>Louis B. Wilmoth, Churchville, Md.</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u></p> <p>(c) <u>Diabetes</u></p>								<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>1 day</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>								<p>19. WAS AUTOPSY PERFORMED?</p> <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>1-3</u>, 19<u>67</u>, to <u>1-4</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>1-4</u>, 19<u>67</u>, and that death occurred at <u>4:35</u> AM, from the causes and on the date stated above.</p>									
<p>22a. SIGNATURE</p> <p><u>Irvin L. Wachsman</u></p>				<p>22b. DATE SIGNED</p> <p><u>1/4/67</u></p>				<p>22c. PHYSICIAN'S NAME (Type)</p> <p><u>Irvin L. Wachsman, M.D.</u></p>	
<p>22d. ADDRESS</p> <p><u>Have de Grace, Maryland</u></p>									
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p>		<p>23b. DATE THEREOF</p> <p><u>7 Jan. 67</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY</p> <p><u>Bel Air Memorial Gardens</u></p>		<p>23d. LOCATION (City, town or county) (State)</p> <p><u>Bel Air, Maryland</u></p>			
<p>24. FUNERAL DIRECTOR</p> <p><u>Walter Macomber Jr.</u></p>				<p>24b. ADDRESS</p> <p><u>Aberdeen, Md.</u></p>		<p>25a. REC'D BY REGISTRAR</p> <p><u>JAN 9 1967</u></p>		<p>25b. REGISTRAR'S SIGNATURE</p> <p><u>[Signature]</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00803				CERTIFICATE OF DEATH				00803			
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HARFORD DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> <u>121</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>295 PARADISE RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>JULIA</u> Last <u>WIRSING</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>3</u> Year <u>1967</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 April 1904</u>		9. AGE (in years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Harford County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John G. F. Morlok</u>						14. MOTHER'S MAIDEN NAME <u>Rozella A. DeMartin</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>George E. Wirsing, Aberdeen, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Decubula</u> 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Acute Passive Congestion of Internal Organs</u> DUE TO (c) <u>Calcific Aortic Stenosis - probably Rheumatic</u>										INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>PPR</u>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>JAN. 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN. 2, 1967</u> , and that death occurred at <u>5:20</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Peter P. Rodman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>1-3-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>				22d. ADDRESS <u>Law St, Aberdeen, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5 Jan. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Paul Lutheran</u>		23d. LOCATION (City, town or county) (State) <u>Aberdeen, Maryland</u>			
24. FUNERAL DIRECTOR <u>Walter Lucomb Jr.</u>				ADDRESS <u>Tarring Funeral Home</u>				25a. REC'D BY REGISTRAR <u>JAN 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
				Aberdeen, Md.							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00804

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00804

1. PLACE OF DEATH a. COUNTY Harford		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Md.		c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		d. STREET ADDRESS 17-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert		Middle F		Last Wise		4. DATE OF DEATH Month January		Day 14		Year 1967		5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1905		9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months 1		Days 11		Hours 19		Minutes 67		11. BIRTHPLACE (State or foreign country) Virginia	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert F. Wise, Sr.		14. MOTHER'S MAIDEN NAME Sarah Turner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-5411	
17. INFORMANT Mrs. Mary Wise, Port Deposit, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE Gerald C. Palmer M.D.		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		24. DATE SIGNED January 14, 1967		25. ADDRESS (Street, city, town, or county) Bel Air, Md.		26. EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.	
27a. BURIAL, CREMATION, REMOVAL (Specify) Burial		27b. DATE THEREOF 1/18/1967		27c. NAME OF CEMETERY OR CREMATORY Jones Mem. Cemetery		27d. LOCATION (City or Town) (County) (State) Port Deposit, Md. Cecil		28. FUNERAL DIRECTOR See J. Patterson & Son, Perryville, Md.		29. ADDRESS See J. Patterson & Son, Perryville, Md.		30. REC'D BY REGISTRAR JAN 23 1967		31. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00805											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> <u>121</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>						d. STREET ADDRESS <u>Box 239-A RD 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Phillip</u> Middle <u>Rodman</u> Last <u>Woodworth</u>						4. DATE OF DEATH Month <u>JANUARY</u> Day <u>23</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 5, 1932</u>		9. AGE (in years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Livestock Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture Dept.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Newbury, Mass.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ralph M. Woodworth</u>						14. MOTHER'S MAIDEN NAME <u>May H. Brampton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>KOREAN Conflict</u> <u>020-30-1360</u>		17. INFORMANT (Write name and address) <u>Mrs. Carolyn A. Woodworth</u> <u>Box 239-A</u> <u>Bel Air, Maryland 21014</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of Pedicle of the Spleen</u> 204.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Myelogenous Leukemia</u> DUE TO (c) <u>Since 1959</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-22</u> , 1967, to <u>1-23</u> , 1967, that (I) (we) last saw the deceased alive on <u>1-23</u> , 1967, and that death occurred at <u>11:35</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/24/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>						22d. ADDRESS <u>Harre de Grace, Ind.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN. 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Groveland, Mass.</u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>W. Broadway & Williams St.</u> <u>Bel Air, Maryland 21014</u>						25a. REC'D BY REGISTRAR <u>DATE</u> <u>JAN 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

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